

241102

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 22893

REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
BARBER, JOHN P.					8 22 85		85	22	85	2:15A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE		WHITE		MONTH 8 DAY 12 YEAR 1894			91 YRS.			IF UNDER 24 HRS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Md.		U.S.A.					Cecil				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
EIKTON		UNION HOSPITAL					FARM HELPER			FARM	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE	
MD.		CECIL		RISING SUN						P.O. Box 788	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
ANDREW				ANNIE						DAVIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		218-07-4497		Barbara CANTECA			WEST CHESTER, PA.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure											
DUE TO, OR AS A CONSEQUENCE OF (c) Ca Prostate c Metastases											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) this hospital attended the deceased from Jan. 19 84 , to 8-22 1985 , that (1) (we) last saw the deceased alive on 8-21 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Sheelamohan S. Saehdev		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/22/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheelamohan S. Saehdev		22e. ADDRESS 204 Bow St, ELKTON MD 21921									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE CREMATION 8-22-85		23c. NAME OF CEMETERY OR CREMATORIAL R. A. Ferris Co.			23d. LOCATION CITY OR TOWN WEST CHESTER			23e. COUNTY CHESTER	
24. FUNERAL DIRECTOR NAME R. J. Farad, Rising Sun Md.		ADDRESS 116 28 1005		25a. DATE REC'D. BY REGISTRAR Aug 28 1985			25b. REGISTRAR'S SIGNATURE R. J. Farad, Rising Sun Md.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

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246020

STATE OF MARYLAND *85*
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH *22894*

REG. NO. *8/13/85*

1. DECEASED NAME (TYPE OR PRINT) <i>Grace D. Bennett</i>			20. DATE OF DEATH MONTH DAY YEAR <i>89 yrs</i>	21. HOUR <i>204 AM</i>	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAY 27, 1896	6. AGE (IN YEARS LAST BIRTHDAY) 89	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i>	MD.	
10. CITY OR TOWN OF DEATH <i>Elkton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY 99999 19734		
13. STATE Delaware	13c. COUNTY New Castle	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 164 Pine Tree Road		
14. FATHER'S NAME FIRST William	MIDDLE -	LAST Ashpurvis	15. MOTHER'S MAIDEN NAME FIRST Johanna	MIDDLE -	LAST Stock
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 198-26-5944	17. INFORMANT Self---(Pre-arrangements)	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia, probably 20 to aspergilla</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>previous cardiovascular accident</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/23 , 19 85 , to 8/13 , 19 85 , that (I) (we) last saw the deceased alive on 8/12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Kenneth Lewis MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/16/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kenneth Lewis MD</i>	22e. ADDRESS <i>Middle town, Del</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-15-85	23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn Memorial Park, Wilmington, Delaware	23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i> ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. 21921	25a. DATE REC'D. BY REGISTRAR JUL 26 1985	25b. REGISTRAR'S SIGNATURE <i>Julie Twidwell Pendell</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 8 9 5

REG. NO.

238083

DIVISION OF VITAL RECORDS, 301 W. PPRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1a. ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PPRESTON ST., BALTIMORE, MD. 21201 FOR Cremation, Burial, or Removal.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR		2. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- MATED <input type="checkbox"/> 08 11 85										2b. HOUR 24. HOUR 1415			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2b. HOUR 24. HOUR 1415			
Harry		J.		Brower				08-11 19 85							
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 16 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil									
10. CITY OR TOWN OF DEATH Earleville, Md		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co Elkton, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Penns		13b. COUNTY Del.		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21 Second St		99999					
14. FATHER'S NAME FIRST Thomas		MIDDLE		LAST Brower		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE		LAST Strickland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW11		17. INFORMANT 188-05-2118		ADDRESS Eileen Brower 21 second St. Chester						PA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Probable Cardiac infarction</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>															
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Reginald William Stalling, M.D. M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 8/11/85									
EXAMINER'S NAME (TYPE OR PRINT) Reginald Stalling		ADDRESS Bow St Elkton MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 15, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Chester Rural		23d. LOCATION CITY OR TOWN Chester		COUNTY Delaware		STATE Pa.					
24. FUNERAL DIRECTOR NAME Gee Funeral Home		ADDRESS 259 E. MAIN ST. ELKTON MD		25a. DATE REC'D. BY REGISTRAR Aug. 19 1985		25b. REGISTRAR'S SIGNATURE L. Kilmer Pendall									

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(VR A15 ME (5))
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

396

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND B TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORUM PM-1 RETAIN IN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W PRESTON STREET, BALTIMORE, MARYLAND 21201 PERTAINING TO RUDIAL CremATION OR REMOVAL.

NATIONAL INSTITUTE OF MEDICAL SCIENCES 2017 REGISTRATION UNIT 2100

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR					
Debra		Michelle		Clark				<input checked="" type="checkbox"/>				8/ 24/19		85		N					
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTHS		DAYS		HOURS		MIN			
Female		White		AUGUST 24, 1966		19 yrs.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTH		DAY		YEAR			
Maryland		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		Cecil County,						10:35			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		---		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Elkton		Union Hospital		---		Delaware		New Castle		New Castle		New Castle				YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>		19720	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		Rutherford		ADDRESS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Marvin		Dixon		Clark, Sr.		Betty		-		-		Marvin D. Clark, Jr. Elkton, Md. 21921				(IF YES, GIVE WAR OR DATES)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8121		IMMEDIATE CAUSE (a)		Multiple Injuries																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 8:15 P.M. 8/24/1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET Rt. 213, South of Locust Pt. Rd., Cecil, Md.		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN															
Burial		8-27-85		Cherry Hill Methodist Cemetery		Cherry Hill, Md.															
24. FUNERAL DIRECTOR NAME		HICKS HOME		for FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR SEP 3 1985												25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or burial at sea.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22897

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST MAY	MIDDLE H.	LAST ECKER	2a. DATE OF DEATH MONTH YEAR	2b. HOUR				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 2		DAY 25	YEAR 1895	6. AGE (IN YEARS LAST BIRTHDAY) 90 yrs	7. IF UNDER 1 YEAR MONTHS YRS	8. IF UNDER 24 HRS HOURS 14 hrs		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.						
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2440 Blue Ball Road 21921						
14. FATHER'S NAME FIRST Unknown		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE	LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 218-09-9730		17. INFORMANT Mrs. Henrietta M. Mallonee, Elkton, Md.		ADDRESS 21921			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prillary Sepsis</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Congestive Heart Failure</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Terminal Renal Failure</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/16/85</u> to <u>8/16/85</u> , that (I) (we) last saw the deceased alive on <u>8/16/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>JAYANTILAL K. PATEL MD</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>8/17/85</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAYANTILAL K. PATEL MD</u>		22f. ADDRESS <u>123 SINGERLY AVE ELLKTON MD 21921</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-20-85		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery, Baltimore, Maryland		23d. LOCATION CITY OR TOWN		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <u>Ralph E. Hicks</u>		ADDRESS HICKS HOME FOR FUNERALS, ELLKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>AUG 22 1985</u>								

248125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be reviewed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Register and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2 2 8 9 8									
										REG. NO.									
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST ELMER			MIDDLE E:		LAST FOSTER			2a. DATE OF DEATH AUGUST 25, 1985		2b. HOUR 10:12A M				
3. SEX Male		4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR January 18, 1925			6. AGE (IN YEARS LAST BIRTHDAY) 60		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE COUNTRY West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil											
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME, GIVE ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter			12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 162 West Main Street 21921											
14. FATHER'S NAME FIRST Thomas		MIDDLE Henry			LAST Foster			15. MOTHER'S MAIDEN NAME FIRST Addie		MIDDLE -		LAST Massey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2			16c. ADDRESS			17. INFORMANT Mrs. Ada R. Foster, Elkton, Md. 21921											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF ESOPHAGEAL CANCER																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, RECURRENT PNEUMONITIS																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from MARCH 25, 1985 to AUGUST 25, 1985 , that (I) (we) last saw the deceased alive on AUGUST 25, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>Glendon Rayson</i>						22c. DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.										22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.						22f. DATE SIGNED 8-25-85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8-28-85			23c. NAME OF CEMETERY OR CREMATORIAL Church of Christ Cemetery, Elkton, Maryland			23d. LOCATION CITY OR TOWN		COUNTY		STATE							
24. FUNERAL DIRECTOR HICKS		24b. ADDRESS HICKS FUNERAL HOME, ELKTON, MD.			24c. ADDRESS 21921			25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE <i>John Anderson</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						22899	
1 - STATE REGISTRAR			REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR	
JOHN A FITZE			AUGUST 21, 1985			1:50A M	
3. SEX Male		4. RACE White	5. DATE OF BIRTH Dec. 6 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65		
7a. BIRTHPLACE Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH PERRY POINT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Refrigeration
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2127 Graythorn Rd. 21220	
14. FATHER'S NAME FIRST Asper		MIDDLE Fitze	LAST	15. MOTHER'S MAIDEN NAME FIRST Goldie		MIDDLE Spencer	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Elva Fitze, Wife		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST							
DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHO PNEUMONIA							
DUE TO, OR AS A CONSEQUENCE OF (c) PARKINSON'S DISEASE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 30 1985 to AUGUST 21 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 21 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE PREM LAL, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL, M.D.		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/23/85	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith		23d. LOCATION Baltimore Co., Md.		
24. FUNERAL DIRECTOR BEZDZINSKI FUNERAL HOME, ESSEX, MD.		25a. DATE REC'D. BY REGISTRAR AUG 23 1985		25b. REGISTRAR'S SIGNATURE Gina Davidson Rendell			

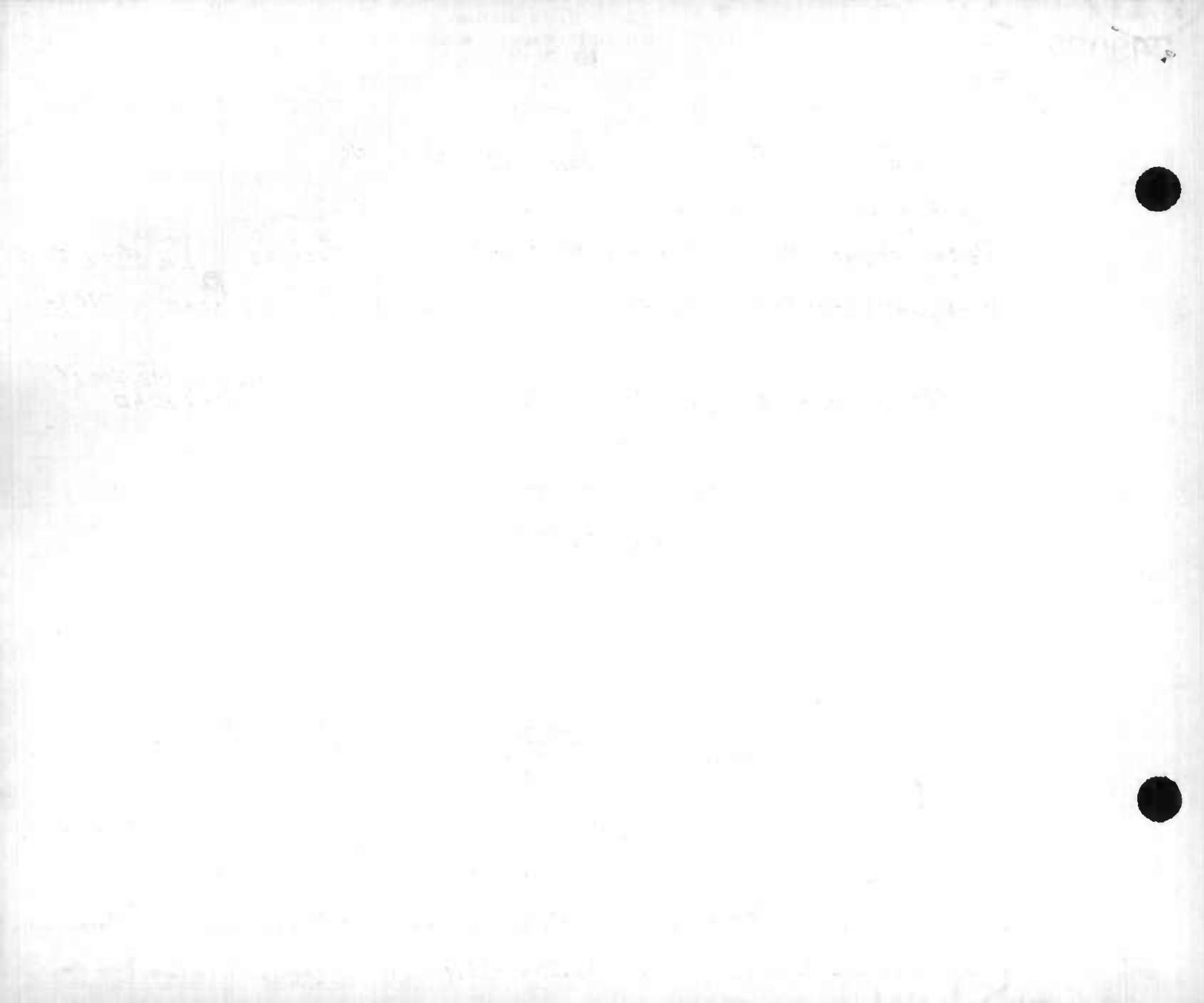


249035

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22900

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
WILLIAM			A	GILES		AUGUST	26	1985	12:25A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		BLACK		MONTH	DAY	YEAR	88	MONTHS	YEARS	MONTHS	YEARS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MARYLAND		U.S.A.				CECIL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
PERRY POINT		VA MEDICAL CENTER PERRY POINT MD		RETIRED		U.S.GOV'T					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		300 OAKINGTON ROAD 21078					
MARYLAND		HARFORD		HARFORD DE GROK							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
UNK						UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		WW-1		717 07 5555		HARFORD DE GROK, MD. 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) PNEUMONIA											
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) COBC, ASCVD, BPH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 21, 1985, to AUGUST 26, 1985, that (I) (we) last saw the deceased alive on AUGUST 26, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE GLENDON E. RAYSON						DEGREE		22c. DATE SIGNED 8-26-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE 25 SEPT. 1985		23c. NAME OF CEMETERY OR CREMATORIAL UNION METHODIST CEM.		23d. LOCATION CITY OR TOWN ABERDEEN HARFORD MARYLAND	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, Aberdeen, Md. 21001-3399						25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE J. DAVIDSON RENDALL			
DHMH - 16 50M 4/83 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be refiled by the hospital or attending physician.

224052

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22901

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
EDWARD Kay					GRAVATT	August 4, 1985			10:15am			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		White		MONTH	DAY	YEAR	63		YRS.	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		U.S.A.						Cecil County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point, Md.		VA Medical Center			Auto Deliverer			Auto Company				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE						
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8701 Rhode Island Avenue 20740			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST			
Theron		Kay		Gravatt	Nellie			M.	Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes-Army		W.W.II		578-16-0124			Perforated duodenal ulcer					
DUE TO, OR AS A CONSEQUENCE OF (b) Acute diffuse peritenditis, severe DUE TO, OR AS A CONSEQUENCE OF bronchial tree, possible gastric pneumonitis. (c) Aspiration of gastric contents into tracheo-												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 14, 1978, to August 4, 1985, <input type="checkbox"/> that in (my) (our) opinion death occurred on the date and hour and from the causes stated xxxxxx xxxxxx xxxxxx xxxxxx xxxxxx xxxxxx												
22b. SIGNATURE <i>OK Nelle</i>		22c. DEGREE <i>Mrs</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8/17/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			VA Medical Center, Perry Point, Md.							
V. NELLORE, M.D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		8/8/85		Fort Lincoln Cemetery			Brentwood		P.G.	Maryland		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Gash's Funeral Home, Hyattsville, Md.					AUG 8 1985							

227083

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22902

REG. NO.

1 - FOR
STATE
REGISTRAR

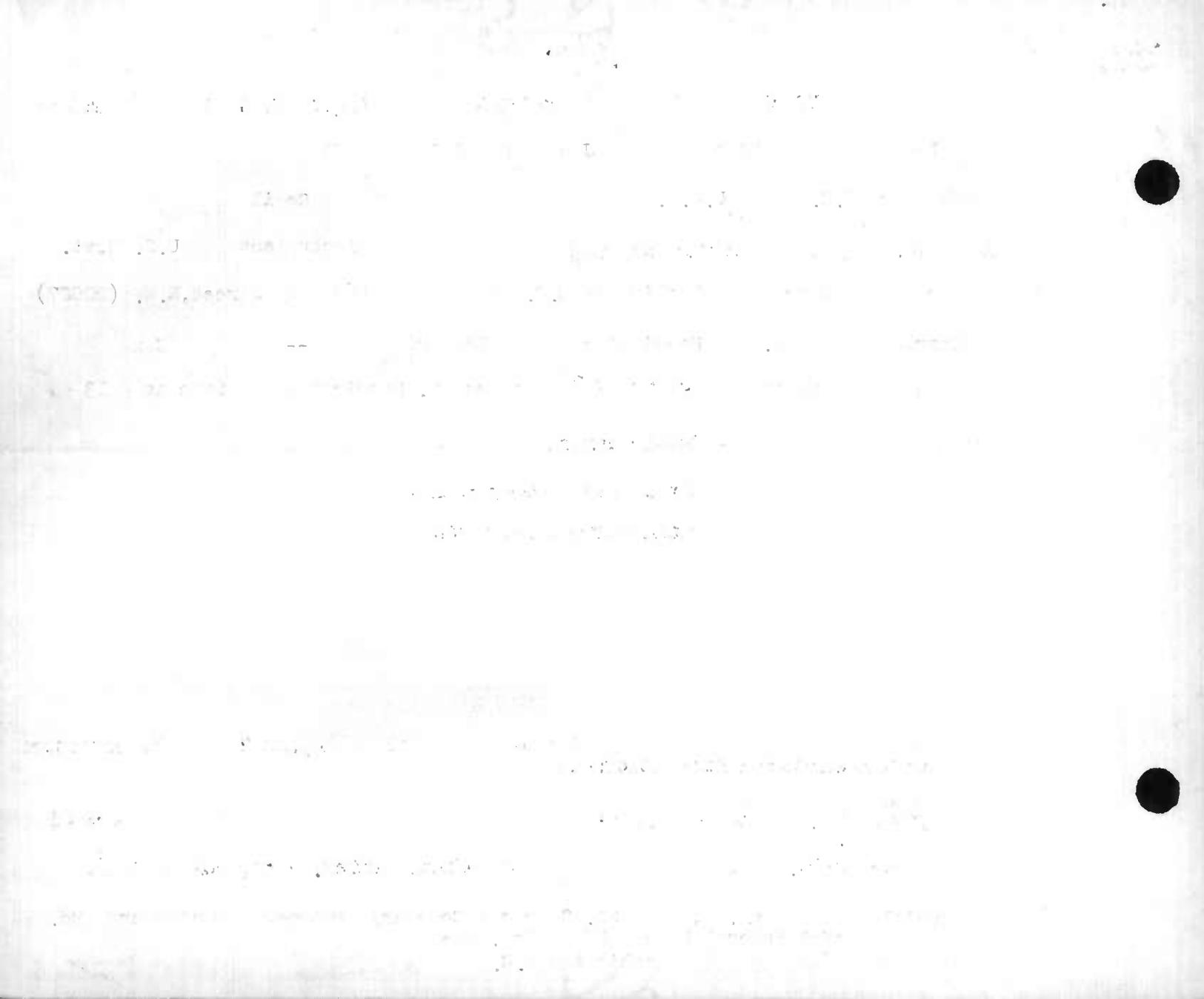
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
			LEONARD	W.	HARRINGTON	August 2, 1985			2:30pm						
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
Male		White	Jan	25	YEAR	73			IF UNDER 24 HRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.						
Washington D.C.		U.S.A.				Cecil MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point, Md.		VA Medical Center			Accountant			U.S. Govt.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE									
13a. STATE None		13b. COUNTY None		13c. CITY OR TOWN Washington D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4632 Q Street, N.W. (20007)		99999					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Charles			A.	Harrington	Leonard			--	Cox						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. WW 11 578-09-0471			17. INFORMANT Wife			ADDRESS						
Yes						Audrey S. Harrington			Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART 1. DEATH WAS CAUSED BY															
IMMEDIATE CAUSE (a) <u>Cardio arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(b) <u>Cardio respiratory failure</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>Bronchopneumonia, right</u>															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
19a.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1983, to August 2, 1985.						and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Gladys Ocejo M.D.</i>						DEGREE									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLADYS OCEJO, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> DATE SIGNED 8-2-85									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Aug. 7, 1985		23c. NAME OF CEMETERY OR CREMATORIAL St. Gabriels Cemetery		23d. LOCATION CITY OR TOWN Potomac		COUNTY Montgomery		STATE Md.	
24. FUNERAL DIRECTOR DeVol Funeral Home						2222 Wisc. Ave		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Robert A. DeSole</i> <i>Joh Davidson-Rendell</i>					
						ADDRESS Washington D.C.		AUG 12 1985							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be held within 72 hours after item 13 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

99999



228124

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 2 9 0 3				
												REG. NO.				
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7 21 19 85			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Leo			William			James, Jr.						2b. HOUR	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR JULY 24, 1955		6. AGE (IN YEARS LAST BIRTHDAY) 29 yrs.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 23 19 85			2d. HOUR 7:30A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILA, PA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County			10. CITY OR TOWN OF DEATH EARLEVILLE				
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) White Crystal Beach-Elk River				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) SELF-EMP. INSULATOR/HOME				12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MARYLAND		13b. COUNTY CECIL		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 374 APPLETON RD 21921								
14. FATHER'S NAME LEO FIRST WILLIAM MIDDLE JAMES LAST SR.			15. MOTHER'S MAIDEN NAME HELEN FIRST MIDDLE LAST MALLEEN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-66-6343			17. INFORMANT parents			ADDRESS HACKS POINT, EARLEVILLE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7 21 19 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown			21f. LOCATION STREET Elk river			CITY OR TOWN		COUNTY Cecil	STATE MD.				
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St. Balto. MD.			DATE SIGNED 7/23/85							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/29/85			23c. NAME OF CEMETERY OR CREMATORIAL St. Rose of Lima Cem Chesapeake city			23d. LOCATION CITY OR TOWN Cecil			COUNTY Cecil		STATE MD.		
24. FUNERAL DIRECTOR Fellows F.H. 226 E. Main St. Cecilton, MD 21913						25a. DATE REC'D. BY REGISTRAR MD 21913 AUG 08 1985						25b. REGISTRAR'S SIGNATURE Julie Davidson-Rodgers				
DHMH 17 (VR A15 ME (5))																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinforce carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be informed and advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 22904	
1. DECEASED NAME (TYPE OR PRINT)			FIRST JACK	MIDDLE Dempsey	LAST JONES	2a DATE OF DEATH August 7, 1985	MONTH YEAR 10:10pm
3. SEX MALE		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 10, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ashe Co. North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.		
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center			12a. USUAL OCCUPATION WELL DRILLER		12b. KIND OF BUSINESS OR INDUSTRY Construction
13. STATE Maryland		13c. COUNTY Harford Co.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1500 Schucks Road 21014		13f. ADDRESS 1500 Schucks Road Bel Air, Maryland 21014	
14. FATHER'S NAME FIRST ALLEN		MIDDLE LAST JONES	15. MOTHER'S MAIDEN NAME FIRST Belle		MIDDLE Flora	LAST Adams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES-Army		16b. SOCIAL SECURITY NO. WW2	17. INFORMANT (NAME) 734-7564 Mrs. Pauline Jones		ADDRESS 1500 Schucks Road Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchopneumonia, acute, severe APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).		DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema of lungs, diffuse, bullous					
		DUE TO, OR AS A CONSEQUENCE OF (c) Fibrous pleural adhesions					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (X) this hospital attended the deceased from March 19, 1980, to August 7, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (They) did not view the body after death.							
22b. SIGNATURE Julian Ocejo, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-9-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 10, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014	COUNTY	STATE
24. FUNERAL DIRECTOR NAME Foster Funeral Home		ADDRESS 50 W. Broadway & Williams St. Foster Funeral Home, Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR AUG 11 1985		25b. REGISTRAR'S SIGNATURE Julian Ocejo, M.D.	

224058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

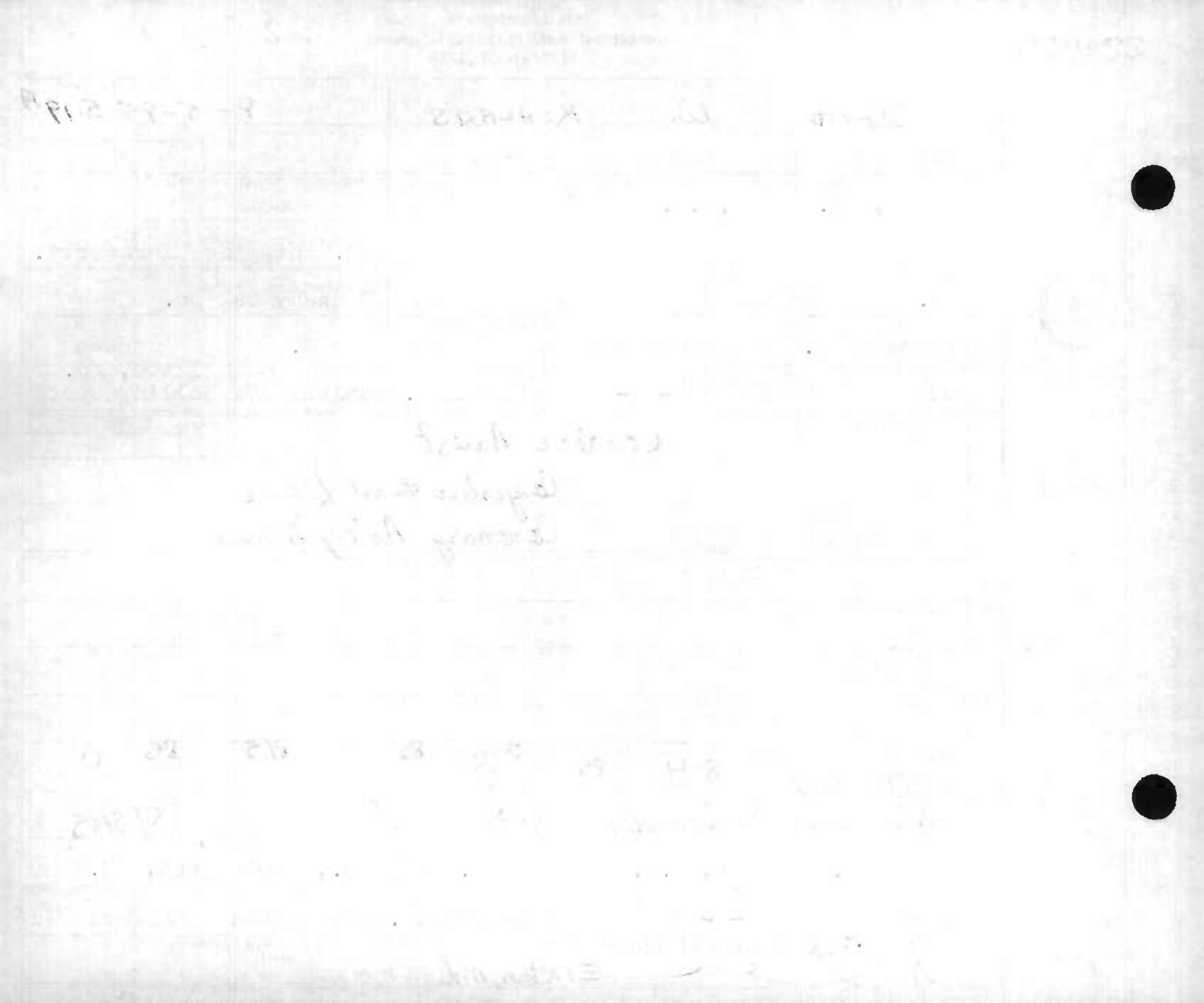
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

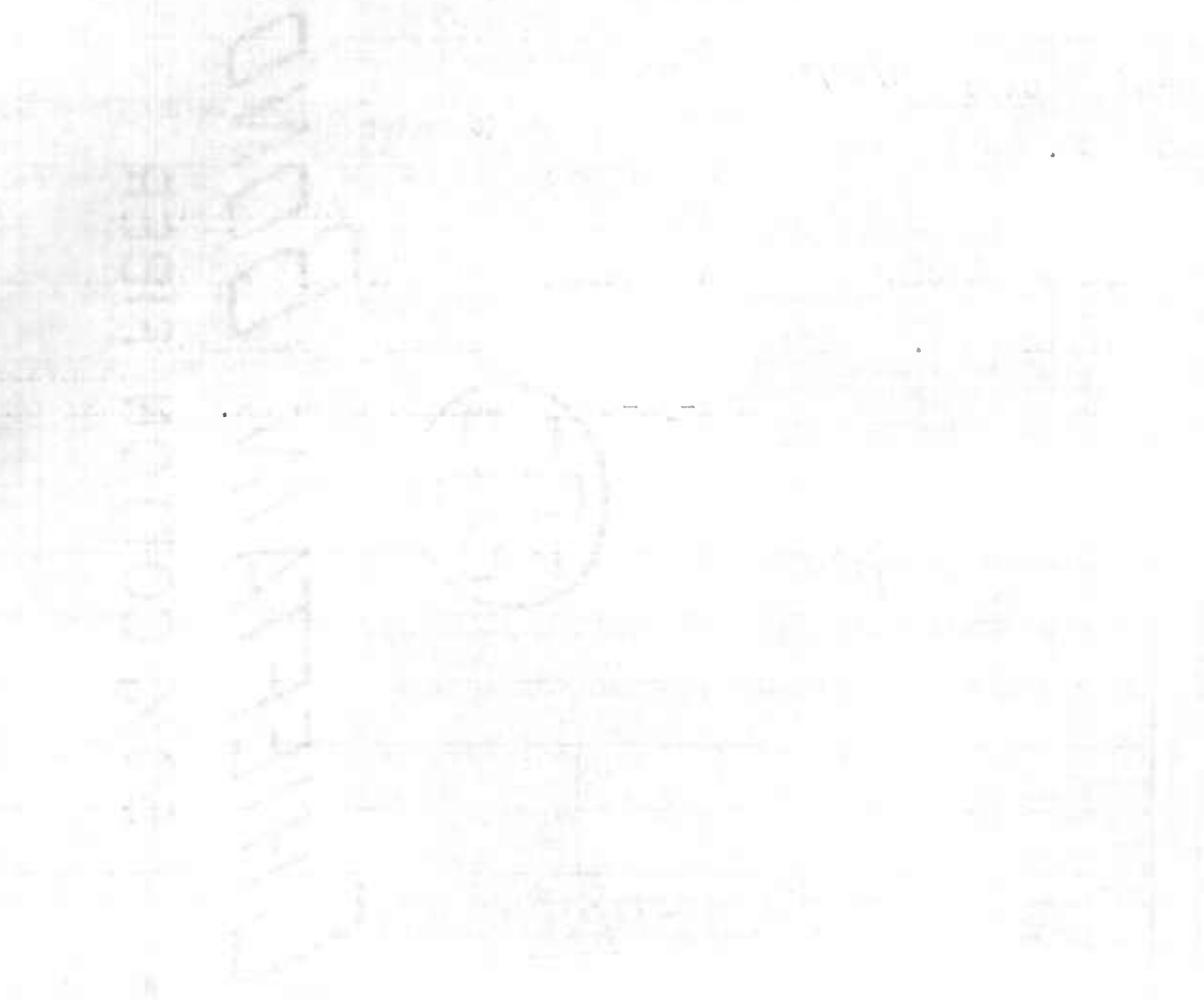
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22905

REG. NO.



221253



239020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22907

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CLOSSIE			J. G.	MENCH		AUGUST 16, 1985			P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		November 6, 1911		73		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital				Foreman- National V. Fiber Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1770 Appleton Road		21921	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
George		L.		Mench		Emily		-		Kelley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS			
No		221-07-8284				Mrs. Phoebe F. Mench, Elkton, Md. 21921					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Central hypoxic shock</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Drake Bell - Hypoxia</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>51</u> , 19 <u>64</u> , to <u>8/16</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>8/2</u> , 19 <u>85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph G. Lanzi</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-19-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				721 Bridge Street, Elkton, Md. 21921					
Joseph G. Lanzi, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		8-21-85		Head of Christiana Pres. Cemetery, Newark, Del. 19711							
24. FUNERAL DIRECTOR <i>Philip E. Hicks</i>		ADDRESS <i>HICKS HOME FOR FUNERALS, ELKTON, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>Aug 22 1985</i>		25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon paper from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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228154

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22908

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
DAVID					MILLER	August 13, 1985				3:35pm			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH 09	DAY 12	YEAR 10	74	MONTHS YRS.	MONTHS DAYS	HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED XX		NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Scotland		USA		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point, Md.		VA Medical Center		Assistant Director		V.A.M.C.							
13a. STATE Maryland						13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 Twin Lakes Road 21904	
14. FATHER'S NAME David		FIRST MIDDLE Miller		LAST		15. MOTHER'S MAIDEN NAME Catherine		MIDDLE		LAST Anderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes		265-09-4431		Margaret L. Miller 108 Twin Lakes Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis, malignant melanoma, right upper lobe of lung.</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 24</u> , 19 <u>85</u> , to <u>August 13</u> , 19 <u>85</u> , <u>XXXXXXXXXX</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Julian Ocejo, M.D.</u> DEGREE													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>			
JULIAN OCEJO, M.D.		VA Medical Center, Perry Point, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Cremation		Aug. 17, 1985		R.A. Ferris & Co.		West Chester				PA			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Patterson & Sons Funeral Home, Perryville, Md.		AUG 14 1985				<u>Jean Davidson-Pandelle</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



224056

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

224056

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Nellie K. Miller						8 - 5 - 85					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		MONTH DAY YEAR 1 - 10 - 10		75 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Tenn.		USA				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Port Deposit		167 Theodore Rd.				Nursing Asst.		Hospital			
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 167 Thodore Rd. 21904			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Joseph				South		Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		216-16-2602		LeRoy E. Miller (same as 13)							
18. CAUSE OF DEATH: (Enter only one cause per line for Part 1, 2, and 3) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a)											
Advanced parkinson's disease											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure											
DUE TO, OR AS A CONSEQUENCE OF dehydration											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from on or about the deceased died on 7/3 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Brian T. Yeo		4. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/5/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN	
Brian T. Yeo, M.D.		801 S. Union Ave., Havre de Grace, Md. 21078		Burial 8-8-85		West Nottingham		Colora		Cecil Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
R. T. Foard Funeral Home, Rising Sun, Md.		AUG 8 1985		John Foard Pendell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner

25

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252038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22910

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR			
LOUIS B. MYRICK						August 15, 1985				6:20pm			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Black	Sept.	8	1922	62		MONTHS	YEARS	MONTHS	YEARS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Georgia		USA	X NEVER MARRIED DIVORCED			Cecil		US Army					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Perry Point, Md.		VA Medical Center			Military		US Army						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13. STREET ADDRESS / ZIP CODE							
13a. STATE Maryland		13c. CITY OR TOWN Baltimore City Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1719 Nome St. Apt. B-3, 21224						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME INST.			MIDDLE						
Alex			Myrick	Lillian			Marshall						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF UNKNOWN OR DATES)	17. INFORMANT			ADDRESS							
Yes		098-28-1388	Mrs. Angelika Myrick			21224							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Aspiration pneumonitis, marked													
DUE TO, OR AS A CONSEQUENCE OF (b) Fibrous peritoneal adhesions between loops of small and large intestines													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 21, 1975, to August 15, 1985, <input type="checkbox"/> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					VA Medical Center, Perry Point, Md.							8-16-85	
VIJAY NELLORE, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		Aug. 20, 1985		Quantico National Cemetery			Quantico		Prince William		Virginia		
24. FUNERAL DIRECTOR		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Patterson & Son Funeral Home		Patterson & Son Funeral Home, Perryville, Md.			Aug. 29, 1985			Julia Davidson-Rosen					
DMDH - 16 50M 4/83 (VRA 15, 4)													

242030

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTHYGIE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22911											
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST Francis			MIDDLE William			LAST O'Brien			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR 8 24 85 167 19								
3. SEX male			4 RACE caucasian			5 DATE OF BIRTH MONTH DAY YEAR 05-13-60			6 AGE (IN YEARS LAST BIRTHDAY) 25 yrs.			7 IF UNDER 1 YR. MONTHS DAYS			8 IF UNDER 24 HRS. HOURS MIN.			2c. DATE PRONOUNCED DEAD			2d. HOUR MONTH DAY YEAR 8 24 1985 617 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County											
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UnEmployed			12b. KIND OF BUSINESS OR INDUSTRY														
13a. STATE PA			13b. COUNTY			13c. CITY OR TOWN Philadelphia			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2068 E. Atlantic Street											
14. FATHER'S NAME FIRST Michael			MIDDLE LAST O'Brien			15. MOTHER'S MAIDEN NAME FIRST Anna Marie			MIDDLE LAST Philips														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Army Reserve			16b. SOCIAL SECURITY NO. 175-56-6357			17. INFORMANT Michael O'Brien			ADDRESS 2068 E. Atlantic St. Philadelphia														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute MI</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASD</i> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>ASD</i> , DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stasis</i>												14. PERSON WHOSE AUTOPSY BETWEEN ONSET AND DEATH 30 min.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Water aspiration</i>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Peter Stavros</i>			TITLE (SPECIFY) M.D. <i>Peter Stavros</i>			EXAMINER'S NAME (TYPE OR PRINT) PETER STAVROS M.D.			ADDRESS Elkton Md.			DATE SIGNED 8/24/85											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-27-85			23c. NAME OF CEMETERY OR CREMATORIAL PARK Phila.			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
24. FUNERAL DIRECTOR NAME <i>Edward McLean</i>			25a. DATE REC'D. BY REGISTRAR AUG 28 1985			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>																	
Gee Funeral Home			259 E. Main St.			Elkton Md.																	

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744



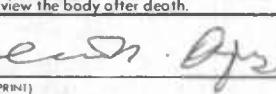
228130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85	22	91	2		
												REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			JAMES FRANKLIN PARCELL						AUGUST 12, 1985						10:02 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male			White			March 10, 1895			90			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
West Virginia			USA						Cecil County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
PERRY POINT, MD			VA MEDICAL CENTER			Carpenter			Construction								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Harford			Perryman						Box 126, Maple Avenue 21130					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
James Madison Parcell			Ellen			233-22-8396			Mrs. Janet F. Parcell, Box 126, Maple Avenue			Perryman, Md. 21130					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ACUTE MYOCARDIAL INFARCTION																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 28, 19 83, to AUGUST 12, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 12, 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.												22c. DATE SIGNED					
22b. SIGNATURE 												DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
MAHMUT N. ATAY, M.D.			VA MEDICAL CENTER, PERRY POINT, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial			Aug. 15, 1985			Bel Air Memorial Gardens, Bel Air			Harford Md.								
24. FUNERAL DIRECTOR Howard K. McComas III, MCCOMAS FUNERAL HOME, ABINGDON, MD. 21009			25a. DATE REC'D. BY REGISTRAR									25b. REGISTRAR'S SIGNATURE 					
												AUG 14 1985					

228152

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22913

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
RICHARD A PAYNE						AUGUST 7, 1985				9:25 P M
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White	April 24, 1914			71				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		
Va.		U.S.A.								
10. CITY OR TOWN OF DEATH PERRY POINT, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Chef			12b. KIND OF BUSINESS OR INDUSTRY Restr		
13. STATE Maryland		14. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 554 Meadowood Drive 21040		
14. FATHER'S NAME Edward R.		15. MOTHER'S MAIDEN NAME LAST Payne		16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		16b. SOCIAL SECURITY NO. 212-03-5045		17. INFORMANT ADDRESS Susan Potter, 554 Meadowood Dr., Edgewood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		VENTRICULAR FIBRILLATION						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) CORONARY ARTERY DISEASE								
{		DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CEREBRAL VASCULAR DISEASE								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CHRONIC BRAIN SYNDROME, ALCOHOLISM										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from JUNE 1, 1985, to AUGUST 7, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 7, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE Glendon E. Rayson M.D.		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED AUGUST 14, 1985					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.								
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Aug. 13, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest Cem.		23d. LOCATION CITY OR TOWN COUNTY		23e. STATE Baltimore, Md.		
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25a. DATE REC'D. BY REGISTRAR AUG 14 1985			25b. REGISTRAR'S SIGNATURE John Davidson, M.D.					
BP										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

233069

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 7 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
WILLIAM BEAUGARD PUGH, JR.						AUGUST 16, 1985				12:05AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Jan. 26, 1922		63		YRS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Belair, Md.		USA				Cecil County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
PERRY POINT, MD		VA MEDICAL CENTER				Plumber		Plumbing			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 732 Ontario Street, Apt. 3		21078	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
William		Beaugard		Pugh, Sr.		Catherine		Victoria		Hicks	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		WWII		216-16-9925		Mrs. Mary A. Pugh, 732 Ontario St., Apt. 3					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 15, 19 85, to 8-16-85, 19 85, that <input checked="" type="checkbox"/> (we) lost the deceased alive on AUGUST 16, 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Glendon Rayson		DEGREE		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 19, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Union Chapel U.M. Cemetery, Joppa		23d. LOCATION CITY OR TOWN Harford		COUNTY		STAFF	
24. FUNERAL DIRECTOR Howard K. McComas III, MCCOMAS FUNERAL HOME, ABINGDON, MD.		ADDRESS 21009		25a. DATE REC'D. BY REGISTRAR AUG 19 1985		25b. REGISTRAR'S SIGNATURE Glendon Rayson					
DHMH - 16 50M 4/B3 (VRA 15, 4)											

248123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22915

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Edward</i>	MIDDLE (NMI) <i>Russell</i>	LAST <i>Russell</i>	2a. DATE OF DEATH MONTH YEAR <i>8/26/85</i>	MONTH <i>Aug</i>	DAY <i>26</i>	YEAR <i>85</i>	2b. HOUR <i>11:00 A.M.</i>
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH OCTOBER		DAY 30, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 83	7. IF UNDER 1 YEAR MONTHS 0		8. IF UNDER 24 HRS HOURS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co		MD.		
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1824 Blue Ball Road 21921				
14. FATHER'S NAME FIRST Edward		MIDDLE -	LAST Russell	15. MOTHER'S MAIDEN NAME FIRST Annabelle	MIDDLE -	LAST Gracey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-38-7528		17. INFORMANT Mrs. Catherine M. Russell, Elkton, Md.	ADDRESS 21921		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b) <i>Congestive heart failure</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (i) (this hospital) attended the deceased from <i>8/26</i> 19 <i>85</i> to <i>8/26</i> 19 <i>85</i> that (i) (we) lost sow the deceased alive an above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. D. Hart</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8-30-85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard Hart</i>		22e. ADDRESS <i>Elkton, Md 21921</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-29-85	23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Methodist Cemetery		23d. LOCATION CITY OR TOWN Cherry Hill, Md.	COUNTY	STATE		
24. FUNERAL DIRECTOR <i>Ralph E. Hickey</i>		ADDRESS <i>HICKIE'S HOME FOR FUNERALS, ELKTON, MD. 21921</i>	25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE <i>via Dawson Pendleton</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be detached for use on the burial/tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, a medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22916

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST WILLIAM	MIDDLE	LAST SCHIFFHAUER	2a. DATE OF DEATH MONTH August 9, 1985	DAY YEAR	2b. HOUR 7:21am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 29 YEAR 1900			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.					
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Retail Store					
13a. STATE Maryland		13b. COUNTY Hartford		13c. CITY OR TOWN Havre DeGrace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 132 Wilson Street 21078				
14. FATHER'S NAME FIRST George		MIDDLE		LAST Schiffhauer		15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE		LAST McCaslin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		16c. INFORMANT M. Naomi Schiffhauer		17. INFORMANT Havre DeGrace, Md.		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						severe, calcific. Atherosclerosis of aorta & carotid arteries,				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis of coronary arteries, marked calcific w/segmental occlusion of more than 90%.		DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarct, old, anterior wall of left ventricle.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (s) (he) (she) (it) (they) (we) (they) attended the deceased from June 19, 1985, to August 9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (in) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Joseph Gondor, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-9-85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH GONDOR, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-14-85		23c. NAME OF CEMETERY OR CREMATORIAL Oaklawn Cemetery		23d. LOCATION CITY OR TOWN Eldredetownship, Lycoming, Pa.						
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service, Reisterstown, Md.				25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE John Anderson-Henderson						

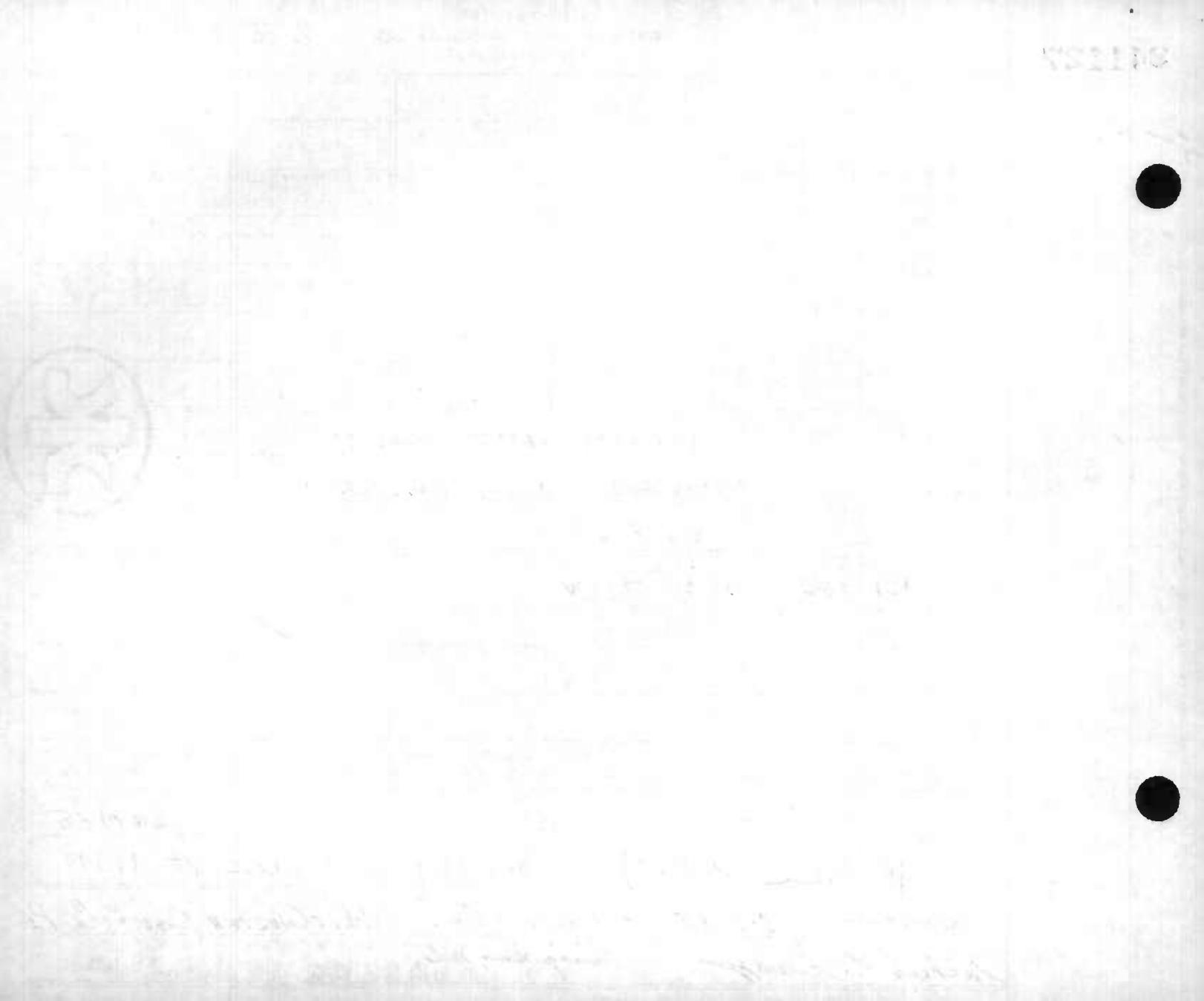
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BP
Retained by the hospital or attending physician.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22917

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Pauline Schmidt						Aug 1, 1985			1:25 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR				
Female		CAUCASIAN		MONTH DAY YEAR Aug 14 1894		90			MONTHS DAYS				
8. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS. HOURS MIN.				
Germany		Germany				Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Rising Sun			Calvert Manor Nursing Home						Factory Worker			99999	
13a. STATE Pa			13b. COUNTY Chester		13c. CITY OR TOWN Avondale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Box 310, State Rd., 19311			
14. FATHER'S NAME Friedrich Gengenbach			15. MOTHER'S MAIDEN NAME Pauline Gengenbach										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) No			16b. SOCIAL SECURITY NO. 193-64-9916			17. INFORMANT Helga Schmidt-Gengenbach, Box 310, State Road, Avondale, PA, 19311			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).			19. DUE TO, OR AS A CONSEQUENCE OF (c) S/P CHF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a OLI HFE DEBILITATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (1) (this hospital) attended the deceased from _____ to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE JK Klein			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 08/01/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JK Klein (KLEIN)			22e. ADDRESS Box 189 WEST GROVE PA, 19390										
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) CREMATION			23b. DATE 8-3-85			23c. NAME OF CEMETERY OR CEMETORY R.A. Ferris & Co.			23d. LOCATION CITY OR TOWN West Chester, Chester Co., PA.				
24. FUNERAL DIRECTOR NAME Richard L. Gandy			25a. DATE REC'D. BY REGISTRAR ADDRESS Rising Sun, Md.						25b. REGISTRAR'S SIGNATURE AUG 23 1985 Julie Davidson-Pendall				



249086

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM 3 RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. INVESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 9 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
David			Andrew	Suggs		<input checked="" type="checkbox"/>	8-31	19	85	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	July 29, 1960	25	YRS.	MONTHS DAYS HOURS MIN.	8-31	19	85	a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.
Marietta, Ga.		USA					Cecil County,			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Elkton			Union Hospital of Cecil County			Manager			Health	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Harford		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		341 George Street 21014		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	
Clarence			Eugene	Suggs	Betty			Ann	Hamilton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
no			221-56-0902			Mrs. Nancy A. Suggs, 341 George St., BelAir			Md. 21014	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

8/199

IMMEDIATE CAUSE (a)

Asphyxia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) Mechanical Compression

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO 21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:20 8-31 19 85

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject trapped under overturned auto

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
road21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 40, Perryville, Cecil County, Maryland

22a. I certify that I took charge of the remains described above, held an

Autopsy , Inspection , Inquiry and in my opiniondeath resulted from Natural causes Accident Suicide Homicide Undetermined manner

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 8-31-85

ACTUAL
SIGNATURE

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Burial

Sept. 3, 1985

BelAir Memorial Gardens, Bel Air

Harford

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

SEP 4 1985 *Julia T. T. [Signature]*

32082

249080

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH22914
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FIRM PEN. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		XX	MONTH	DAY	YEAR	2b. HOUR	
Rodney		Lee		Teat		JR		8-31 19 85		8-31 19 85	6 A.M.	2d. HOUR			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	DATE PRONOUNCED DEAD		8-31 19 85	7:30 a.m.	2e. HOUR	
MALE	W	8-12-60	25 yrs.							9. BALTIMORE CITY OR COUNTY OF DEATH		Cecil County,		MD.	
7a. BIRTHPLACE (STATE OR CITY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		10. USUAL OCCUPATION, TYPE OF WORK OR INDUSTRY		Carpenter Construction	
Elkton, Md		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		11. KIND OF BUSINESS			
12. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. CITY OR TOWN		13. INSIDE CITY LIMITS		14. STREET ADDRESS		15. MOTHER'S MAIDEN NAME		16. ADDRESS		17. APPROXIMATE DURATION BETWEEN ONSET AND DEATH	
Elkton		Union Hospital of Cecil County		Chesapeake City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24 Lamborn Lane		Janice Melvin		Rodney L. Teat, Jr. Chesapeake City			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. (b)		22. (c)		23. ADDRESS			
Multiple Injuries		8150		Multiple Injuries											
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
6:22XX 8-31 19 85		Road		driver of auto struck fixed object											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
				Rt. 310, Chesapeake City, Cecil County, Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		8-31-85					
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smith, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY		COUNTY		STATE					
Burial		9/4/85		Towson Cem		Baltimore		Baltimore		Md.					
24. FURNISHED BY		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Robert C. Hutchins - Middlebury Rd.				SEP 4 1985		Julia Smith, M.D.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

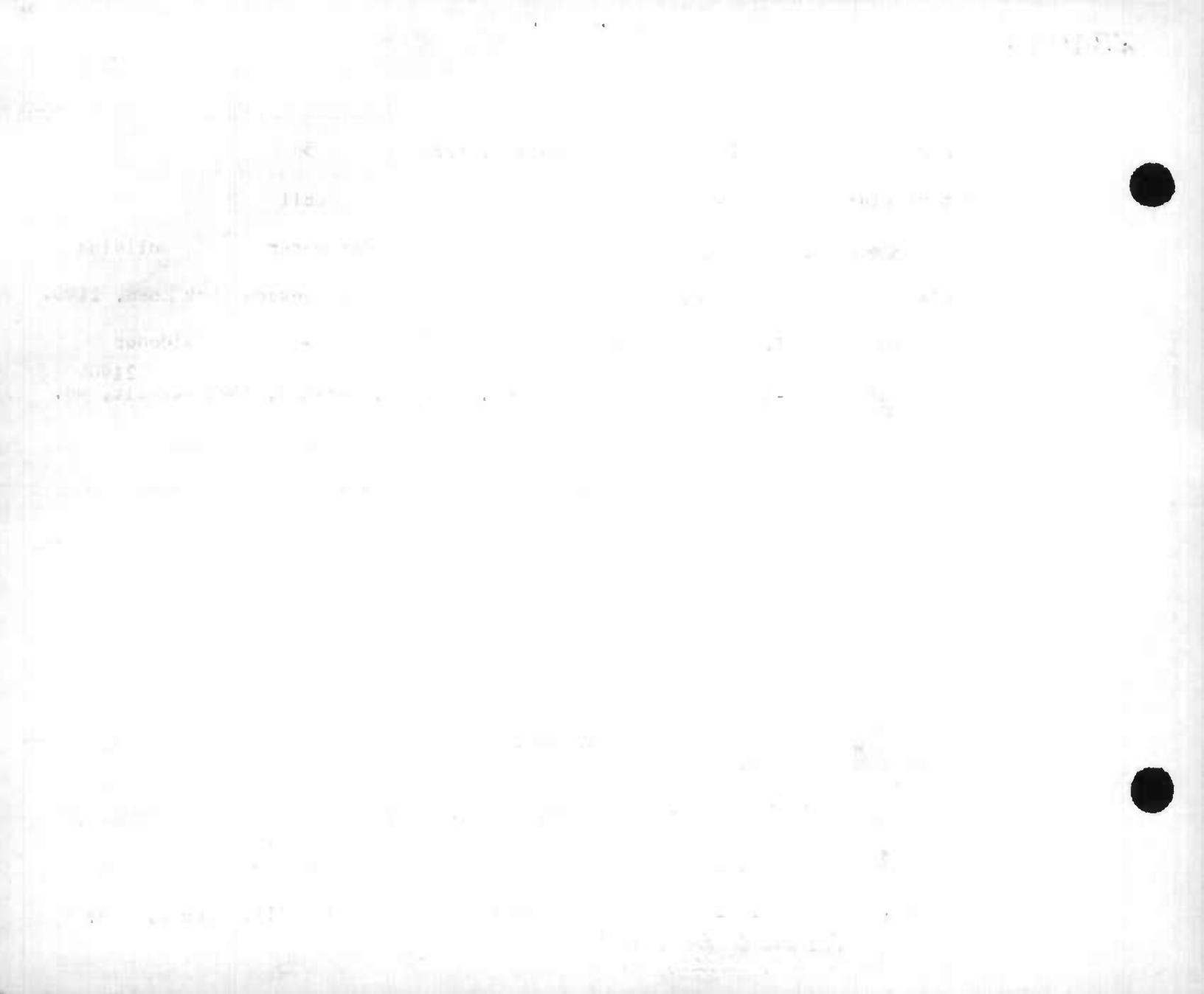
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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 2 9 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST ROBERT	MIDDLE HAROLD	LAST THOMAS	2a. DATE OF DEATH August 13, 1985	MONTH YEAR	DAY 12:30 PM	2b. HOUR								
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 4, 1929	6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		10. CITY OR TOWN OF DEATH Perry Point, Md.									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Building		13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 336 Jackson Park Road, 21904	
14. FATHER'S NAME FIRST Gordon			MIDDLE J.	LAST Thomas	15. MOTHER'S MAIDEN NAME FIRST Vergie		MIDDLE -		LAST Widener								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1946-50		17. INFORMANT Mrs. Helen B. Jackson, Port Deposit, Md.		ADDRESS 21904										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinoma of esophagus - invasive DUE TO, OR AS A CONSEQUENCE OF ASHD with atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 5, 1985, to August 13, 1985, <input checked="" type="checkbox"/> above. <input checked="" type="checkbox"/> (we) (I) did (did not) view the body after death.										22c. DATE SIGNED 8-13-85							
22b. SIGNATURE J. R. GARCIA, M.D.										22d. ADDRESS VA Medical Center, Perry Point, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-16-85		23c. NAME OF CEMETERY OR CREMATORIAL SHARPS CEMETERY		23d. LOCATION CITY OR TOWN Fair Hill, Cecil, Md.			23e. COUNTY STATE							
24. FUNERAL DIRECTOR HICKS HOME Hicks Funeral Home, Elkton, Md.			25a. DATE REC'D. BY REGISTRAR AUG 19 1985		25b. REGISTRAR'S SIGNATURE Wardson-Pendall												



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #3. RETAIN PAGE 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22321		
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF EST. DEATH MATED			2b. HOUR		
			EDWARD Thomas WEITZEL						x 8-30-85 ¹⁹			M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			7. IF UNDER 1 YR. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		
Male		White		3 16 31			54 yrs.					9-1-85 19 8PM M		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.			x NEVER MARRIED DIVORCED			Cecil County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Union Memorial Hospital			Laborer			Railroad					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES x NO			13e. STREET ADDRESS					
Maryland			Baltimore			YES x NO			3215 Fleet Street 21224					
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
William			Dorothy M. Flury			Yes Korea			212-28-1910			John R. Weitzel 7936 Belridge Rd. 21236		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
									YES x NO					
21a. EXTERNAL CAUSE WAS UNDERLYING x OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8-30-85 ¹⁹			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in river								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river (WASHED) (ASHORE)			21f. LOCATION STREET CITY OR TOWN Susquehanna River			CITY OR TOWN COUNTY STATE Cecil Co., Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Margarita A. Korell, M.D.			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 9-2-85					
EXAMINER'S NAME (TYPE OR PRINT)			111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-5-85			23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN Eastwood, Balto. Co., Md.					
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.			ADDRESS 901 S. Conkling St.			25a. DATE REC'D. BY REGISTRAR SEP 5 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson Pendleton					
25. DHMH - 17 (VR A15 ME (5))														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22422					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
BACKS						Whitaker			8/7/85				6:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 19 YEARS			8. UNDER 21 YEARS			
M		B		MONTH DAY YEAR			2 2 09		76			VRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
NC		USA								Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton		Union Hospital								Retired			MD.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
MD.		Cecil		Elkton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		111 Johnstown Rd. 21921						
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST			
Berry				Whitaker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS						
No				705-09-7331			Alberta M. Whitaker same as above								
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) <u>early prostate gland with metastasis to bone & lung.</u>															
(c) <u>ASVD anemia.</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
21d. WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET											
22a. I certify that (I) (we) attended the deceased from <u>4/14</u> , 19 <u>75</u> , to <u>8/7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>6/27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Jui Chih Hsu</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/13/85</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui Chih Hsu</u>		22e. ADDRESS <u>223 West main St, Elkton MD 21921</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>8-14-85</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Griffiths Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Elkton</u>		COUNTY <u>Cecil</u>		STATE <u>MD.</u>				
24. FUNERAL DIRECTOR NAME <u>Arnold W. Beard</u>		ADDRESS <u>353 Fountain St. Havre de Grace</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 19 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Lilia K. Kudra</u>								

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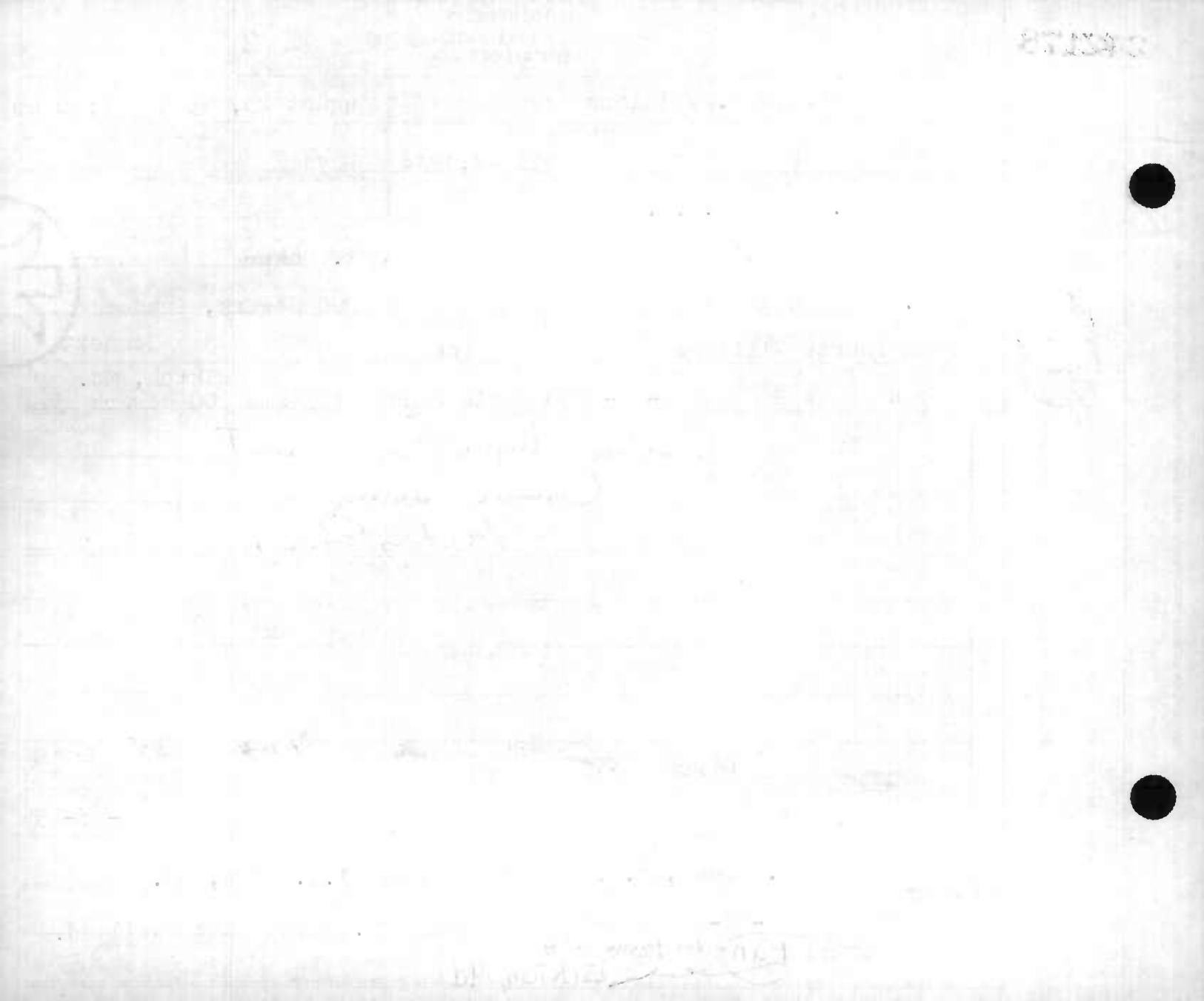
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove or remove with the State of Florida Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or medical condition, the medical examiner should be consulted.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) Charles H. Williams			2. DATE OF DEATH MONTH DAY YEAR August 23, 1985	3. HOUR 6:30 AM
4. SEX Male	5. RACE White	6. DATE OF BIRTH MONTH DAY YEAR April 24, 1914	7. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dover, Del.	10. CITIZEN OF WHAT COUNTRY? U.S.A.	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Union Hospital	12a. USUAL OCCUPATION Ret. Baker	12b. KIND OF BUSINESS OR INDUSTRY Bakery	13. STREET ADDRESS / ZIP CODE 200 Newark, Avenue 21921
13a. STATE Md.	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. ADDRESS Elkton, Md.
14. FATHER'S NAME John Andrew Williams	15. MOTHER'S MAIDEN NAME Ida Bennett	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		
16b. SOCIAL SECURITY NO. WW 2	17. INFORMANT Marie Jones Williams	16c. ADDRESS 200 Newark Ave	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Respiratory Cancer	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost	DUE TO, OR AS A CONSEQUENCE OF Cancer Lung	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b)	DUE TO, OR AS A CONSEQUENCE OF Cancer Brain			
(c)	DUE TO, OR AS A CONSEQUENCE OF Cancer Brain			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>15/22</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death.	21g. DATE SIGNED 8-23-85			
22b. SIGNATURE Joseph G. Lanzi, M.D.	22c. DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 8-23-85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. Lanzi, M.D.	22f. ADDRESS 721 Bridge St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-25-85	23c. NAME OF CEMETERY OR CREMATORIAL North East Meth Cem.	23d. LOCATION CITY OR TOWN	23e. COUNTY STATE
24. FUNERAL DIRECTOR NAME See Funeral Home, P.A. ADDRESS EIKTON MD	25a. DATE REC'D. BY REGISTRAR 7/26/85	25b. REGISTRAR'S SIGNATURE Leigha Pendell		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22424				
												REG. NO.				
1 - FOR STATE REGISTRAR			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			Mildred D. Williams			08-17-85			08-17-85		1435		M			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 05-09-04			6. AGE (IN YEARS LAST BIRTHDAY) 81 Yrs			IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil							
10. CITY OR TOWN OF DEATH Elkton, Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co Elkton, Md			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Md			13b. COUNTY Cecil			13c. CITY OR TOWN North East			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 114 Jethro St			21901	
14. FATHER'S NAME FIRST John MIDDLE Donathe			15. MOTHER'S M AIDEN NAME FIRST Emma MIDDLE			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 181-07-4434			17. INFORMANT Robert P. Williams North East, Md.			ADDRESS 114 Jethro St	
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hypertension, Abnormal heart rhythm, heart embolism																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1975</u> to <u>Aug 17, 1985</u> , that (I) (we) last saw the deceased alive on <u>August 14, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Charles M. Hensgen			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 17 Aug 85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Hensgen			22e. ADDRESS 3 Mauldin Ave. North East, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-20-85			23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer Cemetery			23d. LOCATION CITY OR TOWN Rising Sun Cecil Md.			COUNTY		STATE		
24. FUNERAL DIRECTOR Burton Funeral Home North East, Md.									25a. DATE REC'D. BY REGISTRAR AUG 20 1985			25b. REGISTRAR'S SIGNATURE Lisa Swanson Pendleton				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 2 9 2 5	REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH MATED			MONTH DAY YEAR			2b. HOUR	
Bernard Edward Williamson Jr.						8 4 1985							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2d. HOUR	
Male		White		Aug. 4, 1923		69 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		2d. HOUR	
New York		U.S.A.										8 5 1985 9:35 AM	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Port Deposit			137 Dr. Jack Road						Steamfitter			Shipyard	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD.		
Maryland			Cecil		Port Deposit				137 Dr. Jack Road				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Bernard E. Williamson Sr.			Margaret Shaughnessy										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS				
Yes			W W 11 108-42-0601						Bernardine Lapare, Brooklyn, New York.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Chronic obstructive pulmonary disease</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>J. L. Stohs</i>			TITLE (SPECIFY) M.D. Deputy						MEDICAL EXAMINER			DATE SIGNED 8-5-85	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS										
Juan C. Gonzales-Vitale, MD			Union Hospital, Ellicott, MD 21921										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			STATE	
Burial			Aug. 9, 1985			Quantico National Cem			Quantico			Virginia	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE				
Lee A. Patterson & Son, Perryville, Md.									AUG 7 1985			Gina Burdson-Pendall	

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH22926
REG. NO.

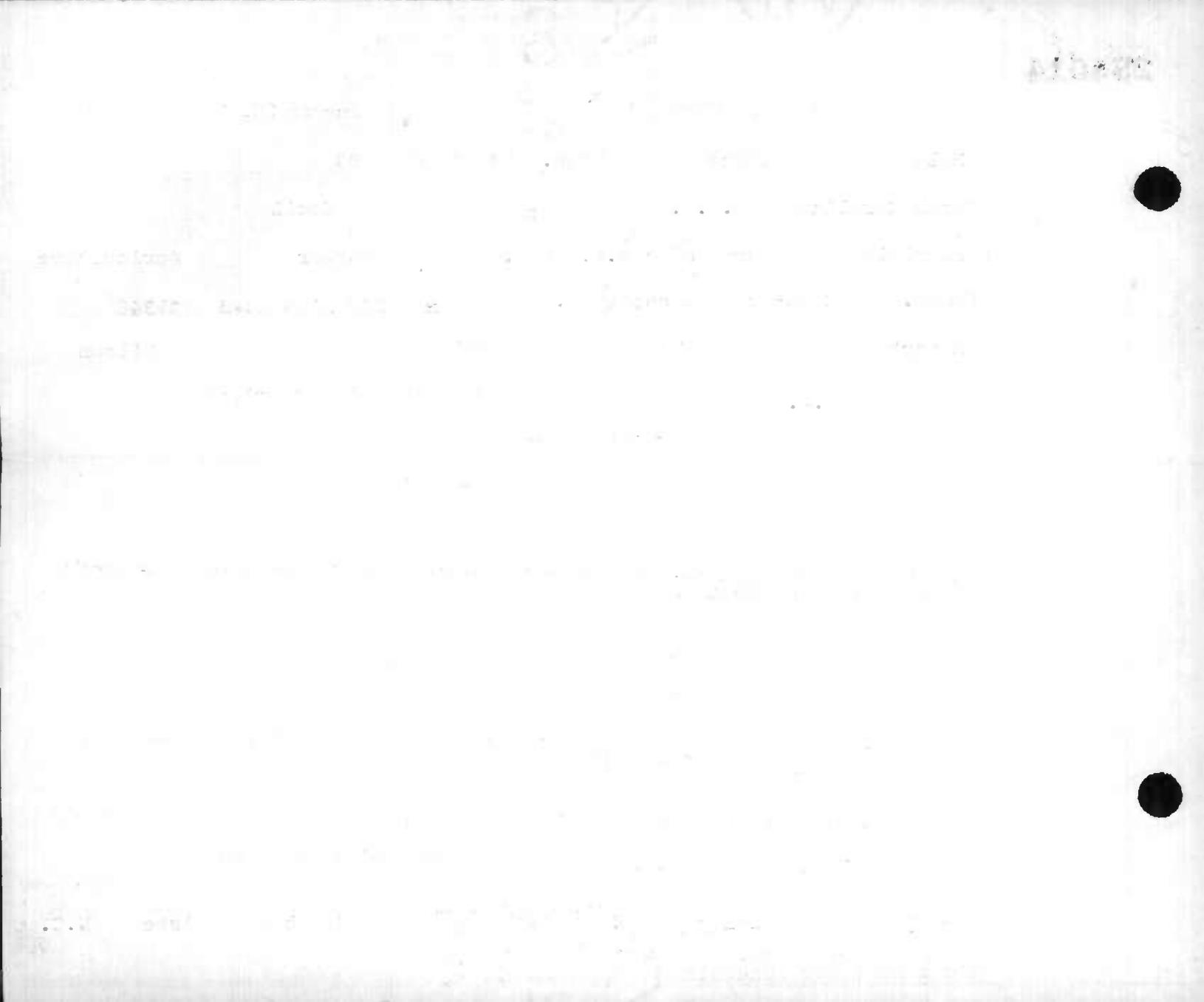
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
Oscar T. Wilson						August 28, 1985				4:50P M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male		White		Feb.	24	1889	96			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
North Carolina		U.S.A.					Cecil								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Perryville		Perry Point V.A. Hosp.			Farmer			Agriculture							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Penns.		Chester		Kennett Sq.					258 Line Road 19348						
FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Robert				Wilson		Ellen					Wilson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
Yes		W.W. I		240 56 6275			VAMC, Perry Point, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia															
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Senile dementia secondary to cerebral arteriosclerosis, prostatic hypertrophy with outlet obstruction.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (D) (this hospital) attended the deceased from saw the deceased alive on 8-28- 19 85 above, (D) (we) (did) <input type="checkbox"/> view the body after death.		22b. SIGNATURE Klaus H. Huebner			22c. DATE SIGNED 8-28-85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
KLAUS H. HUEBNER, M.D.		VAMC, Perry Point, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPEC#)		23b. DATE		23c. NAME OF CEMETERY OR CEMETORY			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial		9-1-85		Wilson Cemetery			Creston			Ashe		N.C.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Tom Folk Funeral Home, West Grove, Pa		SEP 05 1985													
Hicks Home for Funerals															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit. Then please remove carbon adequate. Pages 1 and 2 should be left within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as (D) (we) (did) any injury or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22927

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Edward E. Winner						August 12, 1985				5:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Male		White		Apr. 17, 1905			80			MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Pa.		U.S.A.					Cecil			HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
North East		106 Bayside Dr.		Self-employed			Builder				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Md.	Cecil	North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			106 Bayside Dr. 21901				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST						
Harry		Winner	Ella		Erskine						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS				
No		175-28-2968		Louise Winner			106 Bayside Dr. North East, Md. 21901				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CA of stomach, malignant</u> dehydrated.											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA of stomach</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
MADHU SACHDEV M.D.		3 N. Main St., North East, Md. 21901									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		8-15-85		North East Meth.			North East Cecil Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Trough Funeral Home		North East, Md.			AUG 20 1985			Davidson Pendell			

